DOCUMENTATION OF QUALIFIED MEDICATION AIDE PRACTICUM

State Form 51650 (3-04)
Indiana State Department of Health - Division of Long Term Care

This original form must accompany your application for testing

Student Name:_____ ISDH Approved QMA Training Program: _____

Practicum Site:_____ TOTAL PRACTICUM HOURS: _____

Read Directions Carefully: List **complete** dates (including year) and complete times (including am or pm). Document **only** time spent performing duties & tasks as mandated in the ISDH QMA program. **Do Not include time spent on other duties, breaks or meals.** Use multiple forms as necessary.

Date	Start Time	Ending Time	Total Time	Description of Tasks Completed	Practicum Supervisor (Printed Name)	Practicum Supervisor (Signature)	Student Initials

Total Practicum Hours: _____
I verify that the above stated hours are correct and are the actual times of medication and treatment administration.

RN QMA Program Instructor _____ Student Signature _____Date_____